World Vision Relief & Development, Inc.

WVRD/Honduras FY 92 93
MIDTERM EVALUATION
SAN MIGUEL CHILD SURVIVAL PROJECT
October 31, 1994

Grant No.: FAO-0500-A-00-2042-00

Beginning Date: August 31, 1992
Ending Date: September 30, 1995

Submitted to:

PVO Child Survival Grant Program
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TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AHLACMA	Honduran Association for Maternal Nursing,
ASHONPLAFA	Honduran Association of Family Planning
ARI	Acute Respiratory Infection
CESAMO	***Centro de Salud con Medicos*** y ***Otros;*** i.e., Health Center with Doctors and Others
CDD	Control of Diarrhea1 Diseases
CHV	Community Health Volunteer
cs	Child Survival
CSP	Child Survival Project
CSP-VII	Child Survival Project-VII
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization
FY	Fiscal Year
GM	Growth Monitoring
HIS	Health Information System
KPC	Knowledge, Practice, and Coverage
MOH	Ministry of Health
MTE	Midterm Evaluation
NGO	Non-governmental Organization
ORS	Oral Rehydration Salts
PVO	Private Voluntary Organization
USAID	United States Agency for International Development
WHO	World Health Organization
WV	World Vision
WVRD	World Vision Relief & Development, Inc.

Introduction

The Midterm Evaluation (MTE) of the Child Survival Project-VII (CSP-VII) took place from September to October 1994. The W staff collected information from three different sources to carry out the evaluation: (1) a 30-cluster Knowledge, Practice, and Coverage (KPC) survey, (2) the child survival (CS) project health information system, and (3) focus groups composed of mothers of children under five years old and community health volunteers (CHITS).

The Midterm Evaluation team (MTET) was composed of staff from the Honduran Ministry of Health, who directly responded to some of the questions within the MTE guidelines and provided recommendations for the second half of the project; Dr. Larry Casazza of WVRD/USA, who participated as a KPC Survey trainer and assisted during the final phase of the MTE; Dr. Jose Angel Giron, WV/LACRO Regional office Health Advisor, who assisted in the KPC Survey implementation, and Dr. Marcelo Castrillo, External Consultant, who assisted W/Honduras staff in compiling available data and providing recommendations for the remaining duration of the project.

The main role of the World Vision/Honduras staff was to provide the necessary information to the MTET, and carry out the entire KPC survey in the CS-VII impact area.

Following are the responses according to MTE guidelines:

1. ACCOMPLISHMENTS

How many months has the project been in operation?

The Child Survival Project initiated activities in March 1993 within 10 suburban *colonias* (neighborhoods or suburban communities) of Tegucigalpa (see Attachments la and lb). The project concluded 18 months of field activities; World Vision/ Honduras dedicated the initial months to hiring key staff and procurement.

To date, how many infants, children under five years old, and mothers have been reached by child survival interventions under this project? What proportion is this of the total potential beneficiary population of infants, children under five years old, and women of childbearing age?

The estimated total beneficiary population for the 10 *colonias,* according to the CESAMO (Centro de Salud con Medico: Health Center with Medical Staff) San Miguel's information system, is outlined by year in the following chart:

POPULATION/YEAR

	1993	1994	1995
Children under five years	5,254	5,486	8,137
Infants under one year	1,050	1,097	1,626
Expected number of newborns	1,113	1,150	1,706
Women of fertile age	7,799	8,056	11,950
Total	29,210	30,173	44,750

CHVs , trained by World Vision staff, reached the target population with child survival interventions (see Attachment 2) in the following manner:

- 778 (55%) children under two years old were enrolled in the growth monitoring program.
- 886 children under five years old (18.5%) were immunized (EPI).
- 180 women of childbearing age (2.5%) participated in mothers' support group sessions and family planning counseling.
- Project staff trained 138 (103% of the target) volunteers in growth monitoring; 38 in the control of diarrhea1 diseases (CDD); 87 (65% of the target) in EPI; 62 (46.6% of the target) in ARI; and 38 (28.5% of the target) in facilitating breastfeeding support groups and 21 in family planning (see Attachment 2b for more information).

What has the project achieved up to date in terms of measured inputs (e.g., developed training sessions), outputs (e.g., trained persons, educated mothers), and outcomes (e.g., immunization coverage, chances inmothers' use of ORT)?

The San Miguel CSP Team elected to undertake another KPC survey at the project's mid-term in order to measure the trends in KPC that have occurred since the initiation of the effort.

Following are the results of the 1994 KPC survey of CS interventions:

Acute Respiratory Infections

The DIP objective for AR1 stated that 93% of the mothers would be aware of the signs of pneumonia by the end of the project.

This objective was based on the mistaken baseline survey result of 88% of mothers having knowledge of signs of ARI. However, the actual percentage from the baseline survey showed that 68% of mothers mentioned fast breathing as the main sign of ARI, and only 3% mentioned chest indrawings. Thus, the AR1 objective was overly ambitious for a three-year project.

The 1994 KPC survey results showed that 67% of the mothers recognized fast breathing as the main sign of pneumonia and 46.6% of **CHVs** (62 of 133) were able to identify both fast breathing and chest indrawings as the main signs and symptoms of pneumonia. A total of 43.3% of the proposed target population are currently served by the project.

Control of Diarrhea1 Diseases

The CDD objectives for 1994 were that: (a) 60% of children O-23 months of age with diarrhea in the previous two weeks would be treated with ORT (Litrosol, breastfeeding, and/or other liquids); (b) 45% of children O-23 months of age with diarrhea in the last two weeks would not receive antibiotics; and (c) 70% of children O-59 months of age would receive deworming therapy twice a year.

The 1994 KPC survey results showed that 59% of the mothers breastfed more or the same amount to their children with diarrhea in the last two weeks, 57% gave more or the same amount of liquids, and 48% gave more or the same amount of food; 37% of the children with diarrhea in the last two weeks were treated with Litrosol (ORS), liquid or cereal rehydration; and 43.3% of the infant population of less than two years of age were attended by **CHVs.** Antibiotic use is still high among the children, as is contact with the health center personnel when mothers seek care beyond the household level. In these cases, the health care workers may be **"overtreating"** the diarrhea or may be using antibiotics to treat complex cases when the mother thinks that the diarrhea is the single cause of infection.

Expanded Program on Immunization **(EPI)**

The EPI objectives for 1994 were to reach the following level of coverage: (a) 5% for BCG, 90% for DPT, 90% for OPV and 84% for measles vaccine; and (b) 75% of women with a child under two years of age would receive at least two doses TT.

The KPC survey results for the Midterm Evaluation showed that:

- The EPI access rate (DPT-1) for children of 12-23 months of age was 98%.
- The EPI coverage rate (OPV-3) for children of 12-23 months of age was 85.8%.

- The measles vaccination coverage rate for children 12-23 months of age was 84%.
- The drop-out rate for DPT-1 to DPT-3 was 1.6%.
- Overall drop-out rate (BCG-measles/BCG) was 0.8%.
- The TT2 coverage rate for women with a child O-23 months old was 55.7%.
- 87.2% of children 12-23 months old had completed their immunization schedule (OPV-3, DPT-3, measles vaccine and BCG).

Nutrition

The nutrition objective for 1994 was that 50% of infants under six months of age would be exclusively breastfed.

The 1994 KPC survey results for the Midterm Evaluation showed:

- 37.1% of infants under six months of age were exclusively breastfed.
- 28% of mothers with a child under six months of age are receiving counseling in exclusive breastfeedingpractices from a CHV.

Family Planning

The FP objective for 1994 was that 10% of the mothers with children under two years of age who do not wish to get pregnant will be using a modern method of contraception to avoid or delay pregnancy.

The KPC survey results for the Midterm Evaluation showed that:

- 25.3% of mothers of children of less than two years of age are using a modern method of contraception.

- 57.3% of women of childbearing age were referred for family planning counseling by CHVs.

2. RELEVANCE TO CHILD SURVIVAL PROBLEMS

What are the maior causes of child mortality and morbidity in the project service area?

Death registration in the Health Center San Miguel is still a problem due to under-registration at the community level. However, the main causes of infant mortality and morbidity registered at the CESAMO San Miguel were as follows:

- The total number of deaths of infants under 12 months of age were two in 1993, and three in 1994 (through September). The two infant deaths in 1993 were due to diarrhea and pneumonia, and the three deaths in 1994 were

due to diarrhea1 diseases.

- The main cause of consultation at CESAMO San Miguel was acute respiratory infections. The breakdown of AR1 cases was as follows: pneumonia, 10%; pharyngitis, 38%; upper respiratory infections, 47%; and others, 5%.

In general, mothers did not seek assistance at the clinic when their children were undernourished but rather for some other reason. In the CESAMO San Miguel, there were no cases of severe malnutrition registered. However, 40% of children under five who attended the clinic from January through July 1994 showed some degree of malnutrition.

The estimated total infant population covered by the clinic in 1994 was 64%.

What are the child survival interventions and health promotion activities initiated by the project?

The W CS project used a growth monitoring intervention as the main intervention to introduce the project into the community. This was followed by activities to improve the nutritional status of children, and the utilization of EPI, CDD, API, and reproductive health services (see Attachment 3). Health promotion activities were accomplished by volunteer workers who worked directly with the community.

Is the mix of project interventions appropriate to address the key problems, riven the human, financial, and material resources available to the project and the community?

Yes, the mix of CS interventions were appropriately chosen and address the key problems given the W/Honduras resources and capabilities. Community volunteers selected by the community members, have been actively promoting CS activities and have gained the confidence of those mothers with whom they work.

Is the focus or prioritization of interventions appropriate?

Yes, the focus seems appropriate; i.e., mothers' support groups are providing orientation and counseling on reproductive health and breastfeeding. This has been the main strategy in the first stage of the project for working with women of childbearing age and gaining their confidence.

3. EFFECTIVENESS

What is the relationship between accomplishments for this period and objectives for this period?

From the information provided from the MTE, the evaluation

team concluded that the main accomplishments for the project were:

- A greater percentage of CHVs are able to recognize both signs and symptoms of pneumonia and make timely referrals.
- The immunization coverage for children under five years of age and TT coverage for women of reproductive age increased to achieve the level for this period.
- The percentage of children exclusively breastfed increased.
- W/Honduras provided the San Miguel Health Center with EPI and family planning training materials.

Are targeted high-risk groups beincr reached effectively?

W/Honduras used a ratio of one CHV per family, which allowed them to properly identify high-risk groups and implement CS interventions directly to these groups.

4. RELEVANCE TO DEVELOPMENT

What are the community barriers to meeting the basic needs of children?

The W/Honduras CS project staff's main focus has been to work at the community level with CHVs and mothers' groups, with CHVs referring patients to the clinic when necessary. However, the CESAMO San Miguel physicians focus their energies mainly on clinical practice giving little attention to community and household-level activities. This hindered coordination at the community level.

There have not been real barriers at the community level to the implementation of the Child Survival Project. However, socio-economic conditions in the project area are among the worst for the city of Tegucigalpa. There are insufficient income sources, and most women do not carry out any income-generating activities (73% according to the KPC survey). But the community's acceptance of the project itself has been very positive.

What has the PVO project done to date to increase the ability of families to participate in and benefit from child survival activities and services?

Health promotion and CS interventions have been accomplished through training and deployment of CHVs in the community at-large. The San Miguel Health Center serves as the CHVs' main referral site.

But, the project's relationship with the CESAMO San Miguel is

less than optimal. The MTET recommended that W/Honduras and the CESAMO health staff develop more joint activities. The evaluation team also recommended that community members be included in the project planning and implementation processes.

Is the PVO fostering an environment which increases community self-reliance, and enables women to better address the health and nutrition needs of their families?

It is W/Honduras's priority to strengthen self-reliance of families and women in particular. Gender analysis work has just started. The project has emphasized the selection of female CHVs with the purpose of gaining credibility and acceptance in their communities. In turn, these CHVs work directly with mothers in the communities to empower them to know what they can do at home to prevent illness and treat simple cases of diarrhea and ARI, and when to seek referral.

The project coordinates all its activities with the health center, including case referrals. On some occasions referrals were not attended appropriately at the health center, which decreased the CHVs' self-confidence (see report of focus groups in Attachment 4).

5. DESIGN AND IMPLEMENTATION

5.1 Design

Has the project limited its project area or size of impact population?

W/Honduras strategically broke down the target population into three areas, assigning one facilitator (field supervisor) per area. The total target population is distributed in 12 communities, or sectors. The CSP team has implemented activities in ten communities or *colonias* and left the remaining two for the second phase of the project.

Has there been a careful expansion of project service activities?

During 1993 and *1994,* W/Honduras worked with a total population of 30,173 in 10 communities of San Miguel. In 1995, the project coordinator will include two more communities in order to reach the proposed target population of 44,735 people.

In addition, W/Honduras will hire two facilitators for these additional two communities. The project coordinator will also redistribute facilitators and CHVs among the 12 communities.

World Vision staff had initially distributed facilitators and

CHVs on a per-block basis, but the team learned during the first phase of the project that facilitators and CHVs ought to be distributed on a population basis, rather than a geographic basis.

Has the PVO set measurable objectives of outputs and outcomes?

The DIP has set clear and measurable objectives based on key CS indicators. Additional indicators were established to respond to WV information needs. WV/Honduras is completing the project's health information system. CHVs are currently recording all data in a notebook. WV staff summarize the data for decision-making use. WV/Honduras is currently designing a computerized health information system to facilitate data processing and reporting.

Has the project management been willing to make changes when appropriate, and can the PVO justify or give a reasonable explanation of the directions and strategies the project has undertaken?

The project management is flexible in the decision-making process. Data analysis and follow-up is done with the participation of all members of the health team.

The initial strategy has been to work with families per block (15 families per CHV). Each facilitator per area is in charge of a certain number of volunteers per block. Volunteers are trained in child survival interventions; they in turn will teach mothers in the community and provide follow-up. There have been no changes in this strategy since the initiation of the project. CS project staff will reinforce and expand this strategy. The CESAMO San Miguel uses the same strategy when working with CHVs. Their CHVs serve 30 families and have additional intervention responsibilities; i.e., TB, vector control, ETS, and oral health.

The purpose of working by block was to facilitate identification and follow-up of CS activities at the family level, and identify high risk groups. CHVs are trained to respond and solve specific health problems. Each volunteer has a map with the location of the families they serve. The goal is that CHVs will act as health agents.

5.2 Management and Use of Data

IS the project collectins simple and Useful data?

The project is collecting data based on 22 key child survival indicators. These 22 were selected from 122 possible indicators.

Do the indicators need refinement?

The indicators could be improved by: (a) refining their operational definition; (b) refining denominators of some indicators; i.e., the denominator for weaning practices is 6-23 months, which may be highly sensitive but provides low specificity; and (c) providing a time definition for some indicators lacking them.

What is the balance between qualitative and quantitative methods of data collection?

The project has concentrated on quantitative information. The team has carried out qualitative surveys but not in a systematic way.

Is the project using surveys for monitoring and evaluation?

Yes, the WV/Honduras CSP team carried out a KPC survey at the beginning of the project. Another KPC survey was conducted to provide information at the time of the Midterm Evaluation. Also, the CS project staff assisted the School of Nursing to conduct a survey of risk factors during reproductive years.

How were baseline data used for project development?

Baseline KPC data was used to develop the Detailed Implementation Plan and to provide a bench mark for trends detected in the second KPC done for the Midterm Evaluation.

Are data being used for decision-making? (Please give examples.)

The results of the baseline KPC survey were used to design the project strategy. The mid-term 1994 KPC survey was used to make recommendations and adjustments to the project strategy. The results of the School of Nursing survey served to initiate a health campaign in reproductive health directed at women of childbearing age. This work was carried out in coordination with CESAMO and the Honduran National University.

Is the project's routine health information system fully functional?

The project's routine health information system is not yet fully functional, but needs further refinement. A total of 107 CHVs were trained (out of 138) to implement the HIS at the community level. WV/Honduras staff is currently assessing the HIS with 32 CHVs.

Do the local staff have the management and technical capacity

required to maintain the health information system?

Yes, the staff members have the technical capacity to maintain the health information system. However, additional training is needed to fully implement the system at the community level and to improve the the supervisory skills of the area facilitators (WV field workers).

Have the results of the information collected been shared with data collectors, project staff, counterparts, and community members?

WV has shared the KPC results of both surveys with key MOH staff at the local and central levels, with community leaders and organized groups, and with USAID project officers. The HIS outputs are not yet processed globally but on a per area basis.

Is the Pvo, headcruarters and/or field, institutionalizing lessons learned by documentins, incornorating, and sharing?

There is a PVO umbrella organization in Honduras which organizes technical meetings with all its members. About one year ago, the umbrella organization organized a workshop with the intention of improving and exchanging information about HIS. These meetings were discontinued because the Honduran MOH is currently revising the national HIS and has requested PVOs to comply with it. This system, when it is finalized, will be shared with other PVOs and MOH.

5.3 Community Education and Social Promotion Evaluation

What is the balance between health promotion/social mobilization and service provision in this project?

WV/Honduras CS project activities focus on health education and promotion; i.e., the communities, organized by blocks, have their own CHVs who work directly with the community and other CHVs. The project did not provide direct health services; these are available through a case referral system.

Is the balance appropriate? Is education liked to available services?

Yes, the balance is appropriate. WV's priority was to educate the CHVs and the community regarding the importance of child survival interventions; i.e., the CHVs' job is to register all children under-fives in their assigned areas or communities, provide follow-up, and refer them when necessary. Education and promotion activities are aimed at raising community awareness and increasing immunization rates as well as involvement in the other CS interventions.

CHVs were trained to refer all cases to the CESAMO San Miguel for further treatment. WV project staff designed a follow-up tool for referrals. This form is still under trial pending the approval of the CESAMO medical director.

Has the project carried out any community information, education, or communication activities?

There has very limited IEC activities conducted by CHVs. Some CHVs are trained to provide education and counseling to mothers in reproductive health. But these, as well as materials used for IEC and counseling, need further refinement as the project considers a revised mix of IEC activities in addition to the one-on-one interaction that has predominated so far.

Was there any attempt to utilize knowledge and practice data, or data from focus groups, in-depth interviews, etc., in developing the messages?

Results of the KPC baseline survey were used to design health education messages and determine the appropriate audiences. The 1994 KPC survey and the information gained from the focus groups conducted at the Midterm Evaluation will also be used to develop new messages.

Have the messages been tested and refined?

The project itself has not yet developed its own system for evaluation of IEC materials because the CS project staff is using materials developed by the MOH and previously field tested.

The training coordinator is responsible for monitoring the consistency of messages delivered by CHVs.

How does the PVO ensure that messages to mothers are consistent?

World Vision staff use standardized materials developed and approved by the Honduran MOH to be sure that messages are consistent. CS project staff also use materials developed by other PVOs and NGOs in the country; i.e., Project HOPE, AHLACMA (a NGO promoting breastfeeding) where these have proven to be culturally acceptable and effective.

Does the project distribute any printed materials?

CS project staff distributed a manual on breastfeeding (designed by AHLACMA), together with UNICEF and WHO training materials, and training manuals developed by Project HOPE for CHVs. No original brochures have been developed by the project

for distribution but these are available to visitors at the CESAMO San Miguel.

Do members of the community regard these materials as simple, useful, and of value?

The training coordinator is currently assessing whether these materials are useful and of value to the community. She will evaluate how the training materials have been used at the community level.

Has the project been creative in its approach to community education, such as incorporating any nontraditional or participatory education activities?

CS project staff is using the following techniques for training CHVs and mothers' groups: (a) conducting small groups to facilitate full participation; (b) popular education techniques; (c) delivery of basic, clear messages; and (d) tutorial training methods.

Has the project assessed the level of learning that has occurred with these methods, or is the evidence for effectiveness anecdotal?

The training coordinator and area facilitators informally assess learning and practices during field supervision. There is no formal system to assess the community's level of learning of CS interventions. CS project staff has held focus group sessions with CHVs and mothers regarding CS interventions (see Attachment 4-Results of Focus Group Sessions).

5.4 Human Resources for Child Survival Evaluation

How many persons are working in this child survival project?

WV/Honduras CS staff is composed of one project coordinator, one training coordinator, one administration coordinator, one health information systems coordinator, five field facilitators, and five support personnel for a total of 14 paid full-time workers. In addition, there are 138 CHVs who are not paid.

Does the project have adequate numbers and mix of staff to meet the technical, managerial, and operational needs of the project?

Yes, there are sufficient personnel with the necessary skills to carry out the project's technical, operational and managerial needs. There will be two additional field supervisors to address the needs of the new colonias.

Do these staff have local counterparts?

The CESAMO San Miguel is WV's counterpart in the implementation of CS activities. Their field staff is also distributed by ***colonias,*** but they rotate more often than WV staff, making coordination difficult.

Dr. Izaguirre, CESAMO San Miguel medical director, works in coordination with Dr. Osorno, WV's project coordinator, and the chief nurse coordinates with WV's training coordinator. Dr. Izaguirre and other technical staff participated in the Midterm Evaluation (see MTET members).

Are there community volunteers takins part in this project?

No. Because the communities themselves are not formally organized yet, the project could not access volunteers through an existing infrastructure. But the CS project staff is supporting the development of health committees per area so that each community will be represented when coordinating with CESAMO and other aid agencies. Also WV is reinforcing formal links between the CESAMO and the community. In the strict sense of the word, the CHVs described below are not considered "community" volunteers at this time.

How many are in place?

There are 138 CHVs trained and deployed by CS project staff. They did not participate in project planning but as implementors; however, Dr. Izaguirre and Dr. Osorno are planning to involve CHVs and other community leaders in all aspects of the CS project activities.

Are they multipurpose workers, or do they concentrate on a single intervention?

CHVs are not trained equally in all CS interventions at this time, but rather their training responds to specific health problems in their communities. Health problems were prioritized at the beginning of the project in response to the baseline survey and the HIS. Health training was designed on a modular basis (see Attachment 5). The health training system consists of modules which will allow for eventual training of all CHVs in all CS interventions.

Is their workload reasonable?

CHVs have a flexible schedule of activities; their only work requirement is to visit all of their assigned families (15) once per month. They spend approximately one hour per visit. CHVs also record data in their information notebooks and complete referral forms when needed. They say that this level

of activity is acceptable to them.

How many days of initial training and how many days Of refresher training have been received since the project start?

Initially, CHVs received 12 hours of training on growth monitoring; 8 hours on ARI, CDD, and EPI; and 8 hours on health information systems (HIS), for a total of 40 hours. Later, they also received 8 hours on interviewing techniques and 24 hours of training on reproductive health through workshops and classes. Training also continues at the field level during supervision.

CS project staff have organized visits to other projects. These include: a MOH pilot project on growth monitoring in Copan; a LACRO regional workshop on sustainability by WV/Honduras; a UNICEF community-based drugstore project in the Department of La Paz.

Was the training methodology appropriate for the nature of the health workers' jobs?

The training coordinator reported that CHVs and staff are using training and counseling methodologies appropriately. She also reported that 95 out of 138 CHVs delivered health messages correctly.

Was the length of training sufficient to prepare the health workers to carry out assigned tasks?

CHVs performed their assigned tasks with few problems after training. There is also continuing education at the community level.

5.5 Supplies and Materials for Local Staff Evaluation

What educational or other materials have been distributed to the workers?

The CS project staff received: (a) Facts *for Life,* UNICEF, (b) ARI, CDD, and nutrition materials from Project HOPE/Honduras; and (c) EPI, CDD, GM, and AR1 training materials from the Honduran MOH.

CHVs received: (a) one manual on reproductive health from The Population Council and (b) one manual on the community-based drugstore from UNICEF (with cards and treatment charts).

Do these materials or supplies give any evidence of being used?

Yes, CS project staff use these manuals on a routine basis.

Are they valued by the health worker?

Most manuals deteriorate with use, leading CHVs to request that WV reproduce more of them but made of stronger materials. This is indirect evidence that they are being heavily used.

Are they appropriate to the health worker's job?

Yes, materials distributed for each child survival intervention were developed in accordance with PAHO/WHO recommendations. As these have been rigorously pre-tested, they are assumed to be appropriate; there is no negative feedback from the CHVs.

Do the local staff volunteers have the necessary materials, supplies, and equipment to carry out their current responsibilities?

All CHVs have scales to implement the growth monitoring program, chronometers to count respirations per minute (ARI), and a notebook to register information. Some CHVs are testing the health information system.

5.6 Quality

Do the local project staff currently have the technical knowledge and skills to carry out their current child survival responsibilities?

The WV project coordinator is a physician with public health training; the training coordinator is a registered nurse trained in public health and is former UNICEF staff. Both are in charge of designing and implementing CS interventions and training the CS project technical staff. The project coordinator wishes to expand training to the CESAMO health personnel, in coordination with the medical director.

Do the local staff counsel and support mothers in an appropriate manner?

There is adequate counseling of mothers. However, the project staff recognizes the need to carry out further qualitative evaluations and surveys at the household level to periodically assess knowledge, attitudes, and health practices as well as healthworker performance.

5.7 Supervision and Monitoring

What is the nature of supervision and monitorins carried out in this proiect?

The project coordinator, training coordinator, and

administrative coordinator are in charge of preparing quarterly activity plans based on supervision and monitoring activities carried out by them and the area facilitators in the project.

The WV/Honduras country director supervises the CS project coordinator and provides support if needed. The administration coordinator is also supervised and supported by the national WV office.

The LAC Regional Office based in Costa Rica, and WVRD, Washington, D.C. provide technical support.

Has supervision of each level of the health worker been adequate for assuring uuality of services?

Since the WV/Honduras CS staff is small, the supervision of personnel is regularly scheduled by the training coordinator. In addition, project coordinators assess the performance of personnel twice a year. Supervision of CHVs is carried out by area facilitators, but there is not an established supervision plan for this level.

From the viewpoint of the health worker, how much ***of*** the supervision is **counseling/support,** performance evaluation, on-the-iob education, or administration?

At this point, no evaluation of supervision from the health workers' perspective has been been carried out.

The emphasis of supervision is to support and continue training the CHVs. CS project staff carry out monthly evaluations of field workers' performance in order to assess project attainments and to complement the health information system.

What are the monitoring and supervision requirements for the remainder of the **project?**

The project will continue with the same monitoring and supervision approaches currently in use and will repeat the KPC survey in the Final Evaluation.

5.8 Use of Central Funding

Have administrative monitoring and technical support from the PVO resional or central offices been appropriate in terms of timins, frequency, and needs of the field staff?

The administrative coordinator was trained according to the CS specific finance reporting requirements for WVRD/USA and **USAID.** Support and training in project management and

financing came mostly from the LAC Regional Office in Costa Rica. So far, the technical support and administrative monitoring are adequate.

If not, what constraints does the project face in obtaining adequate monitoring and technical support form PVO regional Or central offices?

None; adequate technical support came from both the LAC regional office and WVRD/USA, as specified in section 5.9 (technical support).

How much central funding has USAID given the child survival cooperative acfreement for administrative monitoring and technical support of the project?

The project has spent US$74,398 of the overall project budget in administration and technical support.

Do these funds serve a critical function? Are there any particular aspects of USAID funding to the Central office of the PVO that may have a positive or negative effect on meeting child survival obiectives?

Yes, USAID CS funds were of vital importance to initiation of activities in suburban communities in San Miguel.

5.9 PVO's Use of Technical Support

WV/Honduras received diverse technical assistance inputs from the LAC Regional Office and WVRD/USA. The following charts summarize all technical assistance received:

External Technical Assistance

DATE	PURPOSE	RESPONSIBLE
March to April, 1993	Design and implement Baseline KPC survey	Dr. Marcelo Castrillo, The PVO CSSP of JHU Dr. Fe Garcia WRD/USA
July 2-4, 1993	Sustainability Workshop	Dr. Fe Garcia, WRD/USA Ms. Carolyn Avila, WRD/USA Dr. David Befus, W LAC Regional Office Mr. Edgardo Vargas, W/Honduras
April to May, 1993	Study on time management of CESAMO health personnel	Ms. Kimberly Baldwin, Loma Linda University, CA
April, 1994	Professional exchange with CS project	Dr. Angel Giron, W/El Salvador Dr. Fe Garcia, WVRD
August, 1994	The USAID Financial System	Ms. Sandra Jenkins, WRD
September, 1994	International Auditing	Dr. Villalta, VM International Mr. Salomón Díaz
August to September, 1994	Design and training on KPC survey for MTE	Dr. Larry Casazza, WRD, Washington Dr. José Angel Giron, W/El Salvador

In Country Technical Assistance

DATE	PURPOSE	RESPONSIBLE
Sept to Ott, 1993	Workshop on strategies to work with CHVs	Dr Fidel Barahona COHASA
October, 1993	Workshop on breastfeeding practices	Ms. Argentina De Chavez, AHLACMA
April, 1994	Assistance on Information Systems	Dr. Alejandro Melara, PAHO
February, 1994	Child Survival Interventions Workshop	Dr. Carlos Villalobos, MCH Division of the Honduran MOH

Exchange and Field Visits

LOCATION AND DATE	PURPOSE	RESPONSIBLE
Bolivia. January, 1993	Third LAC Regional Workshop for CS project Managers	Ms. Rima Loida Cloter and Ms. Marta Castellanos
Rep. Dominicana November, 1993	Assist W/DR on health information systems	Ms. Patricia Alvarez
Copan, Honduras Marzo, 1994	Pilot Project on GM by the Honduran MOH and DESAPER	Dr. Jose Manuel Arita Ms. Italia Valladares Ms. Patricia Alvarez and CHVs

Was the level of technical support adequate, straightforward, and worthwhile?

Yes, technical assistance was adequate and important to the development of the CS project.

Are there any particular aspects of the technical support (from all sources) which may have had a positive or negative effect on meeting the project objectives (e.g., consultants visits, evaluations, workshops, conferences, exchange field visits)?

All the visits and assistance received fulfilled the technical needs of Child Survival Project staff.

Is there a need for technical support in the next six months? If so, what are the constraints to obtaining the necessary support?

Yes, there is a need for further technical support in health information systems, data collection methods for monitoring and evaluating CS project interventions, and IEC-Counseling. There are no major obstacles to obtaining technical assistance; the project manager will include this in the MTE follow-up plan.

5.10 Assessment of Counterpart Relationships

What are the chief counterpart organizations to this project? What collaborative activities have taken place to date?

There are two major counterparts of the CS Project: the project communities, and the CESAMO San Miguel Health Center.

CS project staff collaborated in various activities with counterpart organizations including: (a) meetings to coordinate activities at the community level; (b) training CHVs with CESAMO Health Center health personnel; (c) logistic support; and (d) joint health promotion activities.

Are there any exchanges of money, materials, or human resources between the project and its counterparts?

CS project staff supported CESAMO San Miguel with a) a freezer, IUD insertion materials, and other equipment; b) reproduction of training materials; and c) support to National Mobilization Campaigns organized by the Honduran MOH.

Do the counterpart staffs have the managerial and technical capacity to eventually take on the functions necessary to operate effective child survival activities?

The CESAMO San Miguel health personnel have the technical capacity to continue CS activities, but they are also aware that there are constraints in working with the MOH, such as lack of continuity and technical backstopping in CS interventions.

Is there an open dialogue between the PVO project and counterparts?

Dr. Izaguirre, CESAMO, and Dr. Osorno, W, have maintained open dialogue between both institutions, and are committed to including community leaders in this dialogue to reinforce the health program.

5.11 Referral Relationships

Identify the potential referral care sites and comment on access and service quality.

The CESAMO San Miguel is the referral center for the whole area. There are also other referral institutions outside the MOH structure, such as private hospitals, Honduran Social Security, and Honduran Association of Family Planning (ASHONPLAFA). The health needs of the community surpassed the capacity of w and CESAMO together; quality of service delivery is an issue that will be addressed in the remaining time of the project.

Has the project made appropriate use of these referral sites?

CHVs are referring cases who need further medical attention, which represent 5.5% of the cases received by CESAMO Health Center. However, there are still more improvements needed to refine the referral system.

What is the continuity of relationships between the referral site and the community project?

The CESAMO San Miguel medical director and MOH metropolitan area coordinator wish to institutionalize this referral and counter-referral system, but there are still political barriers to overcome, such as the well-entrenched MOH health personnel unions. Some leaders of these unions believe no other organizations should be allowed to work within the CESAMO service area.

Is the dialogue between project and referral site adequate?

The relationship between management level staff of W/Honduras and CESAMO Health Center is well established and mutually supportive, with close communication, cooperation and collaboration. At the field staff level, however, the turn-over rate among CESAMO outreach facilitators, social workers and nurses and the nature of their union involvement constrains their communication and collaboration with W/Honduras project staff.

Is the project taking any steps to strengthen the services of the referral site or increase community access to site?

W/Honduras is currently constructing a Multi-disciplinary Community Center to work directly with the community. This center will not provide direct health services but will reinforce referral to the CESAMO.

5.12 Evaluation of the **PVOs** Network

what evidence is there of effective networking with other **PVOs** and **NGOs** working in health and child survival?

There is a Honduran PVO umbrella organization which primarily implements health and child survival activities. A rotating board of directors was formed and W/Honduras was in charge of coordinating activities until December 1993; currently Project HOPE coordinates activities.

Two of the activities carried out within the network were a workshop on sustainability in 1993 (W/Honduras) and a health information systems workshop (Project HOPE).

Are there any particular aspects of the situation which may have had a positive or negative effect on networking?

Several meetings were held to standardize indicators and methods for collecting information among PVOs and the MOH; however, this did not respond to some PVO needs. Further, the MOH is currently revising the national HIS; therefore, all standardization attempts are now on hold.

W has signed cooperation agreements with the MOH, the School of Nurses, and the National University. The purposes of the agreements are: (a) to develop and implement new survey methods; (b) to provide students with a learning experience in working with the community; and (c) to provide W/Honduras with new and innovative ideas.

The Honduran Institute for Habilitation and Rehabilitation is seeking to work with PVOs on growth monitoring; W project staff sees this as an opportunity to strengthen CHV training.

AHLACMA, the Honduran Association for Maternal Nursing, has trained CS personnel in breastfeeding and maternal reproductive health counseling. These activities will continue in the second phase of the project.

Can the **project** cite at least one lesson learned from other **PVOs** or other child survival projects?

W/Honduras has profitted from working with the International

Eye Foundation to develop audiovisual training materials in nutrition and the prevention of vitamin A deficiency.

5.13 Budget Management

How does the rate of expenses compare with the project's budget? Is the budget being managed in a responsible but flexible way? Can the PVO justify budget shifts that may have occurred?

Following is the relation between the budget and expenses to date:

	1993	1994
Budget	$350,075	$350,075
Expenses	$257,634	$257,634

W's accounting system was designed to respond to the WVRD and USAID reporting requirements. World Vision International carried out an audit of W/Honduras with positive results. There have been no major budjet shifts.

can the project achieve its objectives with the remaining funding?

The remaining funds are adequate to achieve project objectives.

Is there a possibility that the budget will be underspent at the end of the project?

No.

6. SUSTAINABILITY

6.1 What are the steps the project has undertaken to promote sustainability of effective child survival activities once project funding ends?

W's strategy to promote sustainability is composed of three aspects: (a) by transferring knowledge to mothers and CHVs; (b) each community will have a health representative who will also be linked with local traditional institutions; and (c) communities will be represented in the CESAMO Health Center and private organizations.

6.2 Are the incentives received by community volunteers, project staff, and counterpart organizations meaningful for project commitments? Would those incentives continue once USAID funding ends?

CHVs ' incentives are predominately educational. Some of the

volunteers visited other project areas and benefitted from continuing education courses and other activities aimed to reinforce their individual formation. Finally, W is a Christian organization with the overall goal of serving the community. These factors will not change when USAID funds are terminated.

6.3 How is the community involved in planning and implementation of the project activities? Do community members see this project as effective? Is there a demand in the community for the project activities to be sustained?

The community has not participated in the project planning but only in its implementation. The community perception of the project seems positive, as expressed in the focus group sessions (see Attachment 4).

6.4 Do local orsanizations see the project as effective? Are there any concrete plans for project activities to be institutionalized by local NGOs?

W/Honduras has a fine reputation among local NGOs and within the PVO umbrella group. Some PVOs, like ADRA/Honduras, have used WV's experience with working with CHVs for their own CS project.

The W/Honduras CS project serves as a PHC model to be applied in other LAC countries, with or without USAID CS funds. The LAC regional advisor will closely follow the development of this project and share that experience with other W/LAC health-related projects.

6.5 Is the MOH involved in the project? Does the MOH see this project as effective? Are there any concrete plans for the MOH to continue with particular project activities after funding ends?

W/Honduras is trying to build strong bonds with the MOH at both local and national levels. CS project staff uses key health personnel from the MOH (MCH Division) to carry out training sessions and will continue to do so. W/Honduras will continue CS activities and will apply for extension funding extension for this project, a strategy that is endorsed by the MOH.

7. RECURRENT COSTS AND COST RECOVERY MECHANISMS

Do the project managers have a sood understandins of the human, material and financial inputs required to sustain effective child survival activities?

Yes, the project managers understand and are successfully

managing project implementation activities, project staff, resources and the project budget, and can be expected to continue this through the life of the project. Both W/Honduras and MOH staff recognize the potential constraints to sustaining project activities after the grant funding has ended, but have not formally addressed this issue to date.

what is the amount of money the project calculates will be needed to cover recurrent costs?

The project is not currently addressing the issue of recurrent costs. Project activities to date are educational, rather than direct service; nevertheless, the Midterm Evaluation Team has recommended that the project begin to explore the recurrent costs in this project and possible recovery mechanisms.

Does the community agree to pay for any part of the costs of preventive and promotive health activities?

Community members have not yet been approached regarding contributions toward the costs of project activities. They are participating in the educational programs implemented by the project, and their reaction is favorable. Furthermore, the drop-out rate is very low among community volunteers participating in the project. This suggests that the community is supportive of the project, and that other types of community support may be explored in the future.

Is the Government prepared to assume any part of the recurrent costs?

The Government has clearly stated that although they like the project and would like to support it, they have no funds available to contribute to project activities. The MOH recognizes the constraints to sustaining activity after W involvement ends, and has expressed a desire to see the project continue, but has not committed itself to supporting project activities at their current level.

What strategies is the PVO implementing to reduce costs and make the project more efficient?

The project primarily provides education and training, with considerable involvement of community workers and a very low cost-per-beneficiary. The Midterm Evaluation Team has noted that the project may rely too heavily on community health volunteers. In response to recommendations from the Team, the project has requested technical assistance to develop an information, education, communication (IEC) component, which will allow them to reach a wider population while maintaining their low cost-per-beneficiary.

What specific cost-recover mechanisms are being implemented to offset project expenditures?

The project is not currently addressing issues of cost-recovery.

Are the costs reasonable given the environment in which the project operates; is the cost per potential beneficiary appropriate?

This project's costs are modest, and the cost per potential beneficiary is quite low.

Identify costs which are not likely to be sustainable.

The training and education costs incurred by the project activities can't be absorbed by the CESAMO, and won't be absorbed by the Ministry of Health, either at this point, or when grant funding ends. It is recommended that the project evaluate the level of effectiveness and institutionalization within the community of the health/behavior change messages promoted by the project's educational activities, given that the education sessions themselves are unlikely to be sustainable beyond the life of the funded project.

0. **RECOMMENDATIONS**

What steps should be taken by PVO field staff and headcfuarters for the project to achieve its output and outcome objectives by the end of the project?

W/Honduras CS staff has one more year to accomplish the project objectives. The recommendations cited in detail as answers to the subsequent questions in this section apply to the remainder the project. Together the project manager and staff, with MOH collaboration, will develop an action plan to implement the MTE recommendations.

The project manager will also keep open discussions with key MOH technical staff to maintain current CS service levels and to explore new interventions for the future.

Are there any steps the project and PVO headquarters should take to make the project's activities more sustainable?

Close collaboration with the San Miguel Health Center has been an asset. In its second phase, the project will continue to emphasize educating and training mothers and families on key CS interventions and will upgrade the quality of service delivery. Personnel will also have to upgrade their skills in IEC and social marketing.

There are some unaddressed needs in the community. For example, 42% of mothers with a child less than 24 months of age do not want to have another baby in the next two years, yet they are not using any modern method of family planning. Therefore, the project should develop some activities in response to this specific need.

During the first half of the project, staff became skillful at implementing and using the KPC cluster survey results for project planing. However, CS staff need to complement that information using Rapid Assessment Procedures (RAP) and health information systems.

CS project staff demonstrated ability and knowledge in RAP methods during the Midterm Evaluation, although RAP methods have been underutilized to date.

W/CS technical staff may lack the latest literature on child survival, which can be provided by both WRD/USA and the W LAC Regional Support Office. These resources will be developed.

Regarding long-term sustainability, the project could use reinforcement in the following areas: (a) facilitation and reinforcement of technical skills of CESAMO San Miguel personnel; (b) reinforcement and promotion of all community-based organized groups (the team should aim to accomplish joint activities with members of the community); and (c) reinforcement of activities with a cost recovery component.

Are there any steps the project and PVO headquarters should take to make the project activities more applicable, more personnel competent, or the services of **higher** uualitv?

W/Honduras has already reached a high level of service coverage; however, more efforts are needed to upgrade the quality of services.

CDD: The project is training health volunteers to teach mothers to continue with breastfeeding, liquids, and food for their children with diarrhea, and case referral if needed.

The KPC/94 study has shown that 60% of mothers took their children to the health center, hospital, or to a private doctor, and use of medicines and antibiotics (51.4%) seems to be high. W/Honduras should explore whether diarrhea case management is appropriate and define further areas for training.

Time spent training CHVs does not seem to be enough to manage CDD activities at the community level. Therefore, the

recommendation is to dedicate more time to training for CHVs in the community, and to diversify training to include other members of the community, such as teachers, churches and organized groups.

Pneumonia Control: The main activity of W/Honduras is to train health volunteers to recognize the main signs of pneumonia and case referral. However, only 0.6% of mothers went to the CHV when their children had symptoms of pneumonia **(KPC,** 1994 Study); the majority (80.8%) went to the health center, hospital or private doctor.

WHO has not developed a detailed role for the "volunteer worker," but case management of pneumonia is by trained personnel. Only in isolated communities, where access is a problem, do CHVs play an important role; however, this is not the case in San Miguel. CS project staff ought to redefine the role of CHVs in pneumonia control or to relegate it to competency-based training of CHVs.

W CS staff should explore the possibility of going through the complete WHO training course on ARI. Those courses are usually available through the MOH.

Training in pneumonia control should be in coordination with the CESAMO Health Center personnel in order to develop future joint activities.

Family Planning: The project used a reproductive health manual which The Population Council had developed and tested in Honduras; this was an asset. The next step is to make sure mothers receive appropriate counseling on reproductive health.

W/Honduras should also explore using community-based groups to work in reproductive health, since they are accepted within the community and they are familiar with community-based mechanisms for educating and distributing family planning methods allowed by local authorities.

W/Honduras has initiated coordination with ASHONPLAFA, the Honduran Association for Family Planning, and this coordination will help W to refine their family planning strategies.

The project should also consider whether the personnel currently giving counseling in family planning are the most appropriate to discuss issues with mothers and husbands, young couples, or youngsters.

EPI: The Expanded Program on Immunization has reached optimum levels in the country as measured by access, coverage, and drop-out rates. The Child Survival Project needs to continue

with a maintenance strategy and follow up children who have not completed all their vaccinations.

Information System: CS project staff should make an effort to make the health information system fully functioning. **Any** additional activities, such as sentinel sites, should be continued only after the project's HIS is fully functioning.

Recommendations of the CESAMO Health Center and the Metropolitan Sanitary Region:

1. Establish a joint action plan between ***W*** and the Health Center and monitor its implementation periodically.

2. Annual evaluations and other Health Center evaluations should be implemented by both organizations' staff members.

3. Monitoring and support visits should be carried out more frequently by regional and area authorities.

Are there any steps the project and the PVO headquarters should take to make the lessons learned by this project more widely known by other child survival or development **projects** sponsored by **USAID** or other **PVOs?**

The project will use the regional offices for Central and South America and the PVO Child Survival Support Program of The Johns Hopkins University, to share the project benefits and results with other CS projects.

Finally, are there any issues or actions that **USAID** should consider as a result of this evaluation?

Child survival strategies will be adopted by the W/Honduras National Office in other health projects. The **LAC** regional advisor will also share the experiences of this project with other programs in the region in order to enrich their programs.

The project personnel are developing an action plan to implement the recommendations of the Midterm Evaluation; this will also include joint activities with the CESAMO.

9. SUMMARY

The Midterm Evaluation of Child Survival Project-VIII of W/Honduras gathered data through three activities:

1. A Knowledge, Practice, and Coverage (KPC) Survey conducted in 30 clusters in the San Miguel area, September 6-8, 1994.

Although the KPC Survey was not required for the present evaluation, W/Honduras decided to implement it to provide reliable information to the MTET.

2. Examination of data collected from the W health information system.

3. Focus groups conducted with mothers of children under five years of age.

MTE TEAM **MEMBERS**

The Midterm Evaluation was carried out by the CS staff, MOH local and regional personnel, the Adventist Development and Relief Agency, Acting Director ADRA/Honduras, and an external consultant, who facilitated the evaluation process.

The members of the evaluation team were:

- Dr. Edmundo Osorno, CS Project Coordinator, W/Honduras
- Dr. Larry Casazza, WRD/Washington Office
- Dr. Jose Angel Giron, W/Latin American Region
- Dr. Carlos Izaguirre, CESAMO San Miguel Medical Director
- Patricia Alvarez, Training Coordinator, W/Honduras
- Dr. Jose Manuel Arita, Health Information System Coordinator, W/Honduras
- Gloria Galvez, Area Facilitator, W/Honduras
- Italia Valladares, Area Facilitator, W/Honduras
- Ana Caballero, Area Facilitator, W/Honduras
- Oscar Orellana, Area Facilitator, W/Honduras
- Samuel Morales, Area Facilitator, W/Honduras
- Dr. Mirna De Lobo, Metropolitan Area Coordinator, Honduran MOH

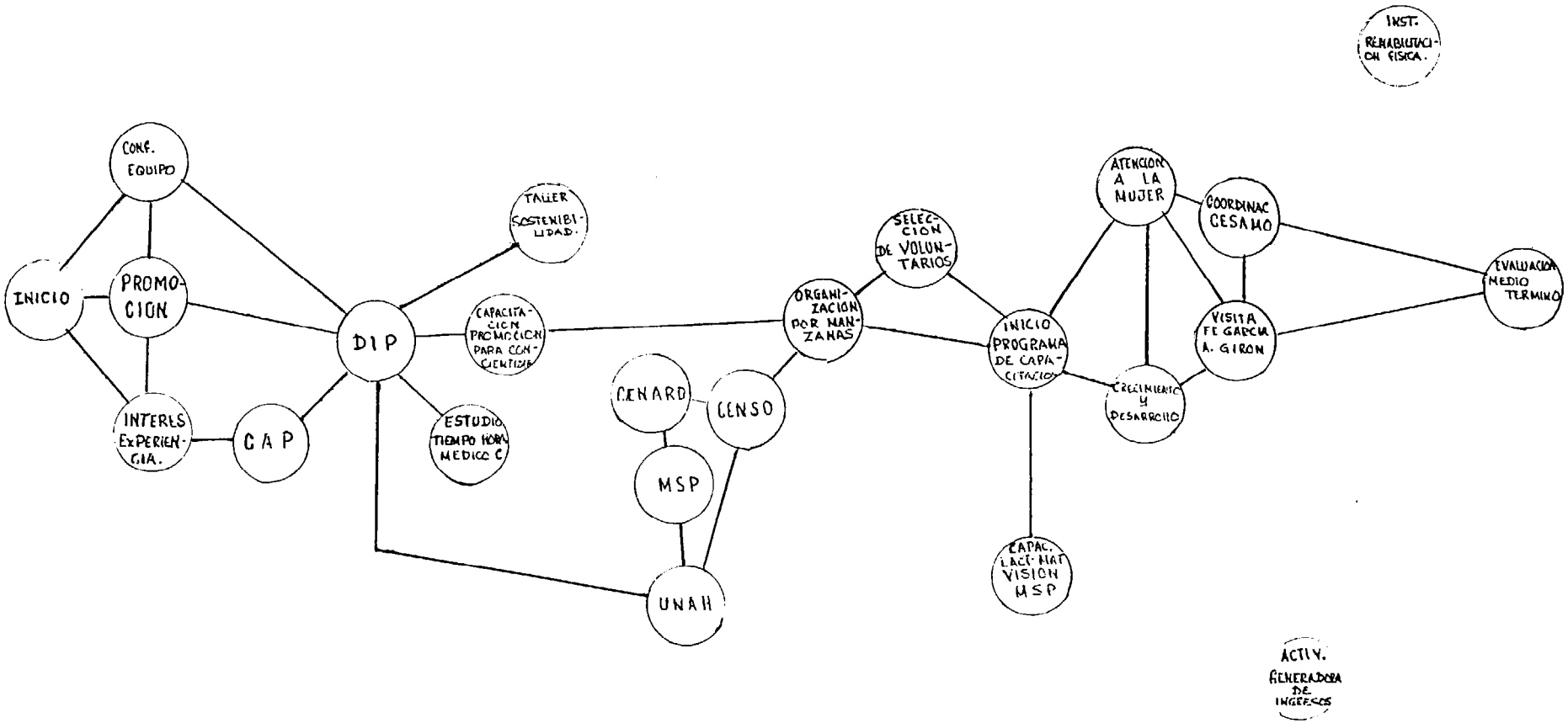
- Dr. Nelson Tabares, CS Project Coordinator, ADRA/Honduras
- Maritza Platero, Nutrition Coordinator, MOH Metropolitan Area
- Liliana Rodriguez, Nurse Chief, Honduran MOH
- Dr. Marcelo Castrillo, Independent Consultant

Total Costs: Not Available at this Time

ANEXO No. 1a

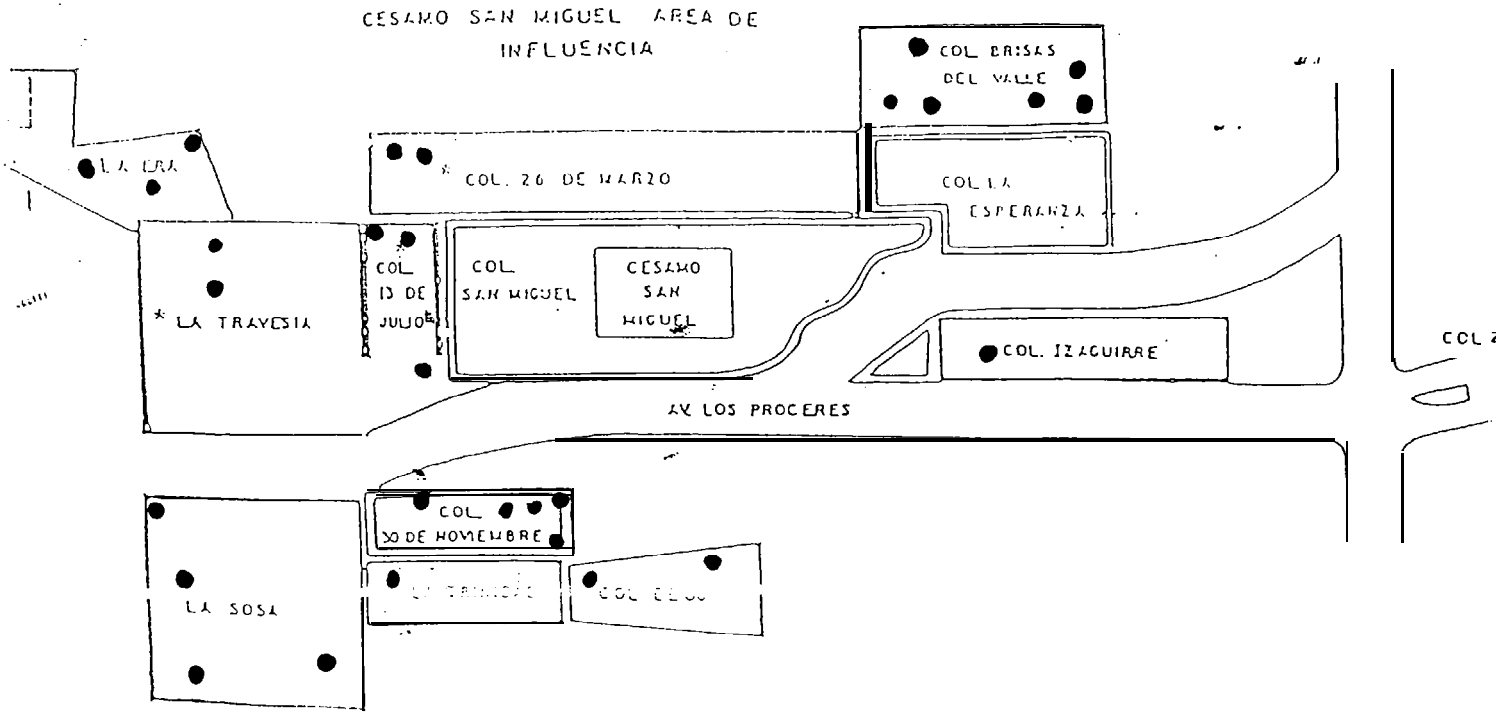
CRONOGRAMA TRIMESTRAL
DE ACTIVIDADES DEL PROYECTO DE SUPERVIVENCIA INFANT-IL

Primer Trimestre	Segundo Trimestre	Tercer Trimestre	Cuarto Trimestre	Quinto Trimestre	Sexto Trimestre	Septimo Trimestre	Octave Trimestre



ANEXO No lb

LOCALIZACION DEL PERSONAL CAPACITADO Y ENTRENADO EN LAS DIFERENTES INTERVENCIONES DEL PROYECTo.II-93



- MUJERES ENTRENADAS EN HACER CROQUIS POR MANZANA Y BACIADO DE INFORMACION CEFASA.
- MUJERES VOLUNTARIAS CAPACITADAS Y ENTRENADAS EN C.YDESARROLLO
- MUJERES VOLUNTARIAS CAPACITADAS Y ENTRENADAS EN CONSEJERIA. DE LACTANCIA MATERNA.
- MJIERES VOLWTARIAS CAPACITADAS y ENTRENADAS COMO VENDEDORAS. EN F.C.M.
- MUJERES VOLWTARIAS CAPACITADAS Y ENTRENADAS PARA FORMAR COMITE
- MUJERES VOLUNTARIAS CAPACITADAS Y ENTRENADAS PARA FONDOS COMUNALES DE MEDICAMENTOS FUNCIONANDO.
- MUJERES VOLUNTARIAS DE SALUD CAPACITADAS W DIARREA.
- MUJERES VOLUNTARIAS DE SALUD CAPACITADAS EN IRA.
- MUJERES VOLUNTARIAS DE SALUD CAPACITADAS EN PAI. REFERENCIA

Attachment 2

WORLD VISION/HONDURAS CHILD SURVIVAL PROJECT

Community Health Volunteers Trained by WV Staff by Child Survival Intervention

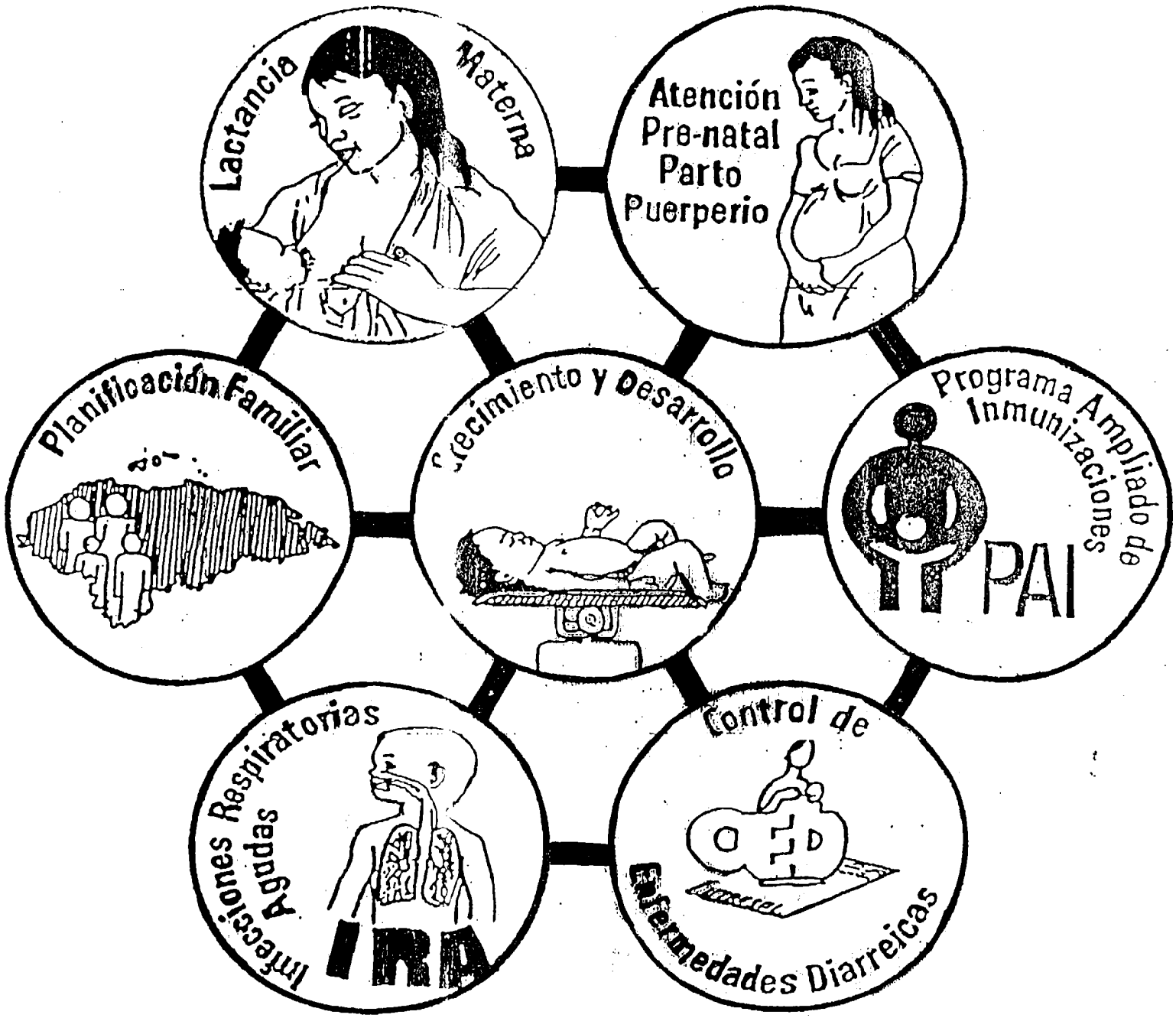
Intervention	Target for FY-94	CHVs trained by 1994	
		#	%
Growth Monitoring	132	138	103
Management of Diarrheal Diseases	132	38	28.7
Immunizations	132	87	65.9
ARI Management	132	62	46.9
Family Planing	132	21	15.9
Breastfeeding Advocates	132	38	28.7

WORLD VISION/HONDURAS CHILD SURVIVAL PROJECT

Infant/Child Population Served by CHVs: Targeted Vs. Accomplished

CS Interventions	Children under 24 months	Assisted by CHVs	
		#	%
Growth Monitoring	2,138	778	36.39
ARI Management	2,138	919	42.98
Control of Diarrheal Diseases	2,138	919	42.98
Immunizations	2,138	886	41.44

ANEXO No. 3


Lactancia Materna
Atención Pre-natal Parto Puerperio
Planificación Familiar
Crecimiento y Desarrollo
Programa Ampliado de Inmunizaciones
PAI
Infecciones Respiratorias Agudas
IRA
Control de Enfermedades Diarreicas
EDD

ATTACHMENT 4

GROUP 1

Location: Tegucigalpa

Date: September 29, 1994.

Focus Group Interviews: Mothers of children under five years old

Mothers were selected from different ***colonias*** of World Vision's impact area.

Question: ***Do you know the CHV assigned to your block?***

Most mothers answered that they knew the CHVs and they worked well. They have also said they have a good interaction with the community. Mothers suggested CHVs should always carry identification because some people do not know them well.

Question: ***How is your relationship with the CHV?***

Some mothers expressed they have very good relationships with volunteer workers, but they insisted that they do not carry identification.

Some other mothers complained about the nurses and the filing system of the Health Center, but in general they thought they were treated well at the CESAMO.

Question: ***What do you do when your child has diarrhea?***

Some expressed that they give them Litrosol immediately, not to avoid breastfeeding, and to give fruit juices. Litrosol is not to treat diarrhea but to rehydrate the child. Others went to the hospital.

Question: ***What are the signs and symptoms of pneumonia?***

Most said that the main signs are fast respiration, fever, and weakness.

Question: ***How is the organization of the community? Do you know the community leaders?***

Some expressed that they only know one of the community leaders. Mothers know their community is organized, but they do not know the leaders very well. Some others said there are other community organizations in the community, such as housewives' clubs, youth groups, and parents' associations.

Question: ***What do you think about the CESAMO?***

Mothers said they had problems with the filing system of the CESAMO, and some references were rejected. There are always some problems in the social area, but things are improving after all.

Question: ***Do you have time to develop activities with your community?***

Mothers said they have enough time to develop activities at any time. Sometimes husbands are not supportive, but they can handle that because what World Vision is teaching will be useful in the future.

Question: ***How was your relationship with the*** project?

The relationship has been excellent and they do not have a problem.

Recommendations:

Provide training in vaccination and other interventions.

Focus Group Interviews: Community Health Volunteers

There were seven health volunteers from different communities.

Question: ***What is the advice you would*** give ***to a mother*** if ***her child is not gaining weight?***

Some expressed that in the first place the mother should deworm the child, then check the weight of the child, and refer them to a doctor.

Question: ***What*** signs ***will alert us that the child*** has ***pneumonia?***

We observe fever, fast respiration, and running nose.

Question: ***What do you do when the child has diarrhea?***

The message about diarrhea is that the mother should give Litrosol to the child; continue breastfeeding; and if the child continues to have diarrhea, refer the child to the doctor immediately, but first give rice water.

Question: ***Could you describe the relation between you and the Health Center? Are people you referred attended?***

Before they had problems with their referrals.

Personnel working at archives and filing do not know health volunteers, and that is the reason to reject the referrals.

They had to go with their “patients" to get them attended. It seems that the people of the CESAMO do not receive referrals from CHVs who were not trained by them.

Question: ***Do you have enough time?***

They distribute their time very well, and they are satisfied with their work.

Question: ***What is your relationship with World Vision?***

They appreciate our work, even though we are not very well educated. They treat us with patience, and we were always supported by them.

GROUP 2

Location: Kindergarten “La Travesia"

Date: September 29, 1994

Focus Group Interview: Mothers' Group

The meeting started with a group of mothers, one facilitator, and one recorder. The meeting developed in an environment of trust.

Response to the first question was that there is a volunteer per each, and they have good relationships with him/her.

Most mothers declared they go to the Health Center because they get a bonus. Some mothers said they do not like to go because they do not accept the referral note from the feeding center program.

One of the volunteers expressed that the attention is bad, and there is bad treatment by the filing personnel and nurses. They agreed that medical attention was very good.

All the participants said that when there is a case of diarrhea they provided Litrosol, liquids, food, breastfeeding, and rice water. One said she took the baby to the volunteer; one indicated that she gave antibiotics.

Signs and symptoms of pneumonia are fast respiration, "boiling **chest,”** fever, blue lips, purulent excretion from the ear, intercostal retractions, and coughing. One of the participants uses homemade nebulization with **Vick's.**

Focus Group Interview: Volunteers' Group

All the group expressed the importance of educating the mother on growth monitoring. Only one of them saw the need for referral.

All of the recognized pneumonia signs: fast respiration, fever, “boiling **chest”** (sounds), and intercostal retractions.

The group advised mothers to: increase liquid intake, provide Litrosol, and continue breastfeeding.

The CESAMO “uses" us in certain occasions.

They attended meetings, but they were not trained. They only discussed the problem with the Health Center-“They do not support us and reject our referrals," and they do not know why they do not get more materials (e.g., Litrosol and condoms).

The CHVs are satisfied with their work because they want to support the community and to dedicate time to this activity.

The **CHWs** feel the project is like their family; they trust them and the project treats them well.

Recommendations

1. Try to integrate volunteers that left the group.
2. Provide enough material, such as Litrosol.
3. Create an infant feeding program.

(1994 COUNTRY PROJECT PIPELINE ANALYSIS - REPORT FORM A

PVO/COUNTRY PROJECT: WVHONDURAS SAN MIGUEL CHILD SURVIVAL PROJECT

GRANT NO. **FAO-0500-00-2042-00**

	Actual Expenditures to Date (08/31/92 t o 09/30/94)			**Projected Expenditures Against Remaining Obligated Funds (10/01/94 to 09/30/95)**			**Total Agreement Budget (Columns 1 & 2) (08/31/92 t o 09/30/95)**		
COST ELEMENTS	AID	PVO	TOTAL	AID	PVO	TOTAL	AID	PVO	TOTAL
I. PROCUREMENT									
A. Supplies	**$23,552**		**$23,552**	$5,960	$39,708	**$45,668**	$29,512	$39,708	$69,220
B. Equipment		**$75,866**	**75,866**	1,120	(16,509))	(15,389))	1,120	59,357	**60,477**
C. Services/Consultants/ Evaluation	29.411		29.411	11.457	0	11.457	**40.868**		**40.868**
SUB-TOTAL I	52,963	**75,866**	**128,829**	**18,537**	**23,199**	**41,736**	**71,500**	**99,065**	**170,565**
II. EVALUATION									
SUB-TOTAL I I	0	0	0	**0**	**0**	**0**	**0**	**0**	**0**
III. INDIRECT COSTS	**35,853**	79,601	**35,853**	**37,747**	**7,942**	**45,689**	**71,880**	164,749	236,629
HQ/HO Overhead __20(%)									
SUB-TOTAL I I I	**35,853**	**79,601**	**35,853**	**37,747**	**7,942**	**45,689**	**71,880**	**164,749**	**236,629**
IV. OTHER PROGRAM COSTS									
A. Personnel	90,207		90,207	91,281	0	91,281	181,488		181,488
B. Travel/Per Diem	27,118		27,118	**42,504**	**0**	**42,504**	**69,622**		**69,622**
C. Other Direct Costs	8,977		8,977	**37.533**	**0**	**37.533**	**46,510**		**46,510**
'(Utilities. Printina. Rent. maintenance, etc.)									
SUB-TOTAL IV	**126,302**	**0**	**126,302**	**171,318**	**0**	**171,318**	**297,620**	**0**	**297,620**
TOTAL	**$215,118**	**$155,467**	**$290,984**	**$227,602**	**$31,141**	**$258,743**	**$441,000**	**$263,814**	**$704,814**